AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Office of Medical Services, U.S. Department of State

Please send the medical information indicated on the following individual to the address listed:

NAME:_____

(Include first, full middle, and last name)

Date of Birth: _____

Scope, or dates to be included:

R Last physical exam only

O Specific document: (specify) _____

O Last three years

J All records in file

Send to:

Name: _____

Address 1: _____

Address 2: _____

City: _____, State _____, ZIP: _____

Signature of requestor: _____

How may we contact you if there are questions?: _____

Relationship of requestor to patient: oSelf, pChild, pOther _____

(Note: Spouses do not have access to medical records without written permission.)

Print name of requestor: _____

Notary stamp, signature, and date:

(Notary required if not submitting request in person. If you are a personal representative, document the basis of authority. Attach power of attorney, etc.)

Mail form to:

Medical Records
Dept. of State
M/MED/EX/MR, SA-1
Washington, DC 20522-0102

OR, fax to: 703-875-4850

email: MEDMR@State.gov

Doc #	Date	Version	Author	Approval
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